MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6027

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural – Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 3 mos., 7 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or Institution? 4 yrs., 3 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Nellie Jo Africa

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 27, 1891

8. AGE: Years: 57 | Months: 4 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business:

FATHER
12. Name: Samuel Africa
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Celeste Camel
15. Birthplace: Pennsylvania

16. Informant: Hospital records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5 1948 (month) (day) (year)

Cemetery or crematory: Cumberland Md.

Location:

18. Funeral director: Charles L. George

Address: Cumberland Md.

19. June 3 1948 (Date rec'd by registrar) Stacy Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1, 1948, at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 25, 1944 to June 1, 1948 and that I last saw h.. alive on June 1, 1948

Immediate cause of death	DURATION
Pulmonary tuberculosis with emphysema	1 mo. known
Due to: Rheumatoid arthritis	10 yrs.
Due to: Huntingtons Chorea	4 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Pulmonary tuberculosis with emphysema

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other

Address: Springfield State Hospital Date signed 6/2/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6028

932d

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster, Md- Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary S. Albaugh.

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or ~~wife~~: Horatio Albaugh
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 27-1870

8. AGE: Years	Months	Days	If less than one day
77	7	16	..... hrs. ..... min.

9. Birthplace: Carroll Co. Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Michael Wilhelm
13. Birthplace: Md

MOTHER
14. Maiden name: Mary A Mackey
15. Birthplace: Md

16. Informant: Arthur Albaugh
Address: Westminster Md. R.D.4

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 16-48 (month) (day) (year)
Cemetery or crematory: Manchester Ref.
Location: Manchester Md

18. Funeral director: Edw. A. Tipton
Address: Hampstead Md

19. 6/14 48 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13th 1948 at 5-A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1- 1947 to June 13- 1948 and that I last saw her alive on June 12- 1948

Immediate cause of death	DURATION
Acute Cardiac Dilatation -	12 hrs
Due to: Chronic Myocarditis	1 yr
Due to: Arteriosclerosis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Chas R. Fouty M.D. M.D. or other
Address: Westminster Md Date signed: 6-14-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

6029

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 77

1. PLACE OF DEATH:
County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Thomas M. Annacort.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	M.

6.(b) Name of husband or wife Julia Rinaman
6.(c) If alive, give age 75 years
7. Birth date of deceased (mo., day, yr.) April 28 - 1870

8. AGE: Years 78 | Months 1 | Days 12 | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business

FATHER
12. Name Staffle Annacort
13. Birthplace 2nd

MOTHER
14. Maiden name Ellen Annacort
15. Birthplace md

16. Informant Mrs Thos M Annacort
Address Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13/48 (month) (day) (year)
Cemetery or crematory Greenmount.
Location Carroll Co Md
18. Funeral director Edw A Tipton
Address Hampstead Md
19 June 10 19 48 John S. Hughes Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1948 at 1:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1948 to June 10 1948
and that I last saw h[illegible] alive on June 9 1948

	DURATION
Immediate cause of death Uremia	2 mths
Due to Obstructive Obstruction	4 weeks
Due to Benign Hypertrophy of Prostate	5 years
Other conditions Arterio-Sclerotic Heart disease	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. C. Porterfield M. D. or other
Address Hampstead, Md Date signed 6-10-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Bc 94a 6030

Reg. Dist. No. 74

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs 2 mo 25 da

Hospital, institution, or street address (if not in hospital)

Springfield State Hospital

How long in hospital or institution 6 yrs 2 mo 25 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME William Brose

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Oct. 17th 1882

8. AGE: Years 65 | Months 7 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Dependent

11. Industry or business

FATHER 12. Name Fredrick Brose

13. Birthplace Germany

MOTHER 14. Maiden name Mary Mozzoe

15. Birthplace Baltimore

16. Informant Henrietta C. Reeder Sanner

Address 330 S. Stricker St. Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15, 1948 (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore Md

18. Funeral director Geo. H. Leimbach

Address 525 N. Lyndenurst St, Balto. Md

19. June 13 1948 (Date rec'd by registrar) Harry Kerr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1948 at 7.25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1942 to June 13 1948 and that I last saw alive on June 13 1948

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr
Due to	
Due to Epilepsy	30 yr
Other conditions Gen. Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE W. F. Austin M.D. M.D., or other

Address Sykesville Md. Date signed 6-13-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52a ✓ 6031

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:

County Carroll

City or town Hampstead Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Hampstead

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Herbert W Bucher.

3.(b) Social Security Number 705-10-8620

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife Naomi Martin

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Sept 5-1896

8. AGE:

Years	Months	Days	If less than one day
51	9	8	..... hrs. ..... min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Railway Service

FATHER

12. Name David B Baker

13. Birthplace Md

MOTHER

14. Maiden name Effie Crowther

15. Birthplace Md

16. Informant Mrs Herbert W Bucher

Address Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16/48 (month) (day) (year)

Cemetery or crematory Greenmount

Location Carroll Co Md

18. Funeral director Edw C Tipton

Address Hampstead Md

19. June 15 1948 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1948, at 10 20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 1948 to June 13 1948 and that I last saw him alive on June 13 1948

Immediate cause of death	DURATION
Metastatic Bronchogenic Carcinoma Lungs	?
Due to Primary Giant Cell Sarcoma	?
Due to Kidney.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury — Injured at work?

23. SIGNATURE Joseph E. Buck M.D. M. D. or other

Address Hampstead Md Date signed 6-13-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6032

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? April 6, 1935

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? April 6, 1935

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 56 Bedford Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Beulah Cecile Carder

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 3, 1888

8. AGE: Years	Months	Days	If less than one day
59	9	16	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Seamstress

11. Industry or business:

FATHER — 12. Name: Benjamin Carder

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Elizabeth Pawnell

MOTHER — 15. Birthplace: Maryland

16. Informant: Vera Carder

Address: 56 Bedford St., Cumberland. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22, 1948 (month) (day) (year)

Cemetery or crematory:

Location: Cumberland Md.

18. Funeral director: Haney Keen

Address: Sykesville Md.

19. June 20 1948 (Date rec'd by registrar) Haney Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 19 48, at 9:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18 19 48, to June 19 19 48 and that I last saw her alive on June 19 19 48

Immediate cause of death	DURATION
Active lung tuberculosis	1 year
Due to:	
Due to:	
Other conditions: Schizophrenia (Include pregnancy within 3 months of death)	

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

SPRINGFIELD STATE HOSPITAL

Address: Sykesville, Maryland Date signed: 6/19/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

6033

CERTIFICATE OF DEATH

Reg. Diat. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as to age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 yrs.

Hospital, institution, or street address where death occurred:

Cranberry, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ralph Albert Carr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12-1908

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
39	9	25		

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name William T. Carr

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Mary Carr

15. Birthplace Carroll Co. Md.

16. Informant Mrs Frank W White

Address Westminster 4. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 9-1948 (month) (day) (year)

Cemetery or crematory Church of God Cemetery

Location Warfieldsburg, Md.

18. Funeral director L Bankard & Son

Address Westminster, Md.

19. 6/8 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION Prim C

20. DATE OF DEATH June 7 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death Drowning. - Probably caused by Epilipsy — DURATION

Due to Epilepsy

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Acc. Date of 6/7/48

Where did injury occur? Rural (City or town) Westminster (County) Md. (State)

Injured at home, farm, industry, public place (where?) —

Means of Injury — Injured at work? —

23. SIGNATURE James T Thomas Deputy Med. Exr. M. D. or other

Address Westminster Md Date signed 6/7/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6034

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? dead on arrival

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium (Colored Branch)

How long in hospital or institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 55½ W. North Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: GRETA LOUISE COOK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 3, 1933

8. AGE: Years	Months	Days	If less than one day
14	11	27	hrs. min.

9. Birthplace: Hagerstown, Md. (Town, county, and state)

10. Usual occupation: scholar

11. Industry or business

FATHER — 12. Name: Allan Ellsworth Cook

13. Birthplace: Sharpsburg, Md.

MOTHER — 14. Maiden name: Natalie Marie Jones

15. Birthplace: Hagerstown, Md.

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof July 3, 1948 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: William H Downes

Address: 291 Frederick St. Hagerstown Md.

19. June 30 1948 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 1948, at 3:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1948, to June 30 1948 and that I last saw h alive on (dead on arrival) 19

Immediate cause of death	DURATION
Miliary tuberculosis	6-16-48
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M. D. M. D. or other

Address: Henryton, Md. Date signed: 6-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 116 JUN 22 1948 **CERTIFICATE OF DEATH**

Reg. Dist. No. 74

6035

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs. 2 mos 23 da

Hospital, institution, or street address (If not in hospital): Springfield State Hospital

How long in hospital or institution? 11 yrs. 1 mo 23 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: —

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Agnes Cornwall

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1893

8. AGE: Years	Months	Days	If less than one day
55 45			..... hrs. ..... min.

9. Birthplace: Pa (Town, county, and state)

10. Usual occupation: Dish Washer

11. Industry or business: at Home

FATHER — 12. Name: Robert Price

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Elnora Cropley

MOTHER — 15. Birthplace: Md.

16. Informant: Rhea Shelton

Address: Selma Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 1948 (month) (day) (year)

Cemetery or crematory: Springfield Hospital Cem.

Location: Sykesville Md.

18. Funeral director: Harry Kerr

Address: Sykesville Md.

19. June 12 1948 (Date rec'd by registrar) Harry Kerr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9th 1945 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 1937 to June 9th 1945 and that I last saw h~~er~~ alive on June 9th 1945

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to:	
Due to: Systemic Syphilis	8
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. J. Masten M.D. M. D. or Other

Address: Sykesville Md. Date signed 6/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46f

6036

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 E. MAIN ST.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mary Catherine Costin

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	MARRIED

6.(b) Name of husband or wife: Thomas Richard Costin 6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): June 7, 1878

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	0	11		

9. Birthplace: BALTIMORE MD. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: JAMES DOBBIN

13. Birthplace: MD.

MOTHER

14. Maiden name: ANNIE F. FLECKENSCHILDT

15. Birthplace

16. Informant: THOMAS R. COSTIN

Address: WESTMINSTER MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: JUNE 21 - 48 (month) (day) (year)

Cemetery or crematory: LORRAINE PARK CEMETERY

Location: BALTIMORE MD.

18. Funeral director: J. F. REESE

Address: WESTMINSTER

19. 6/19 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 1948 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1948 to June 18 1948 and that I last saw her alive on June 18 1948

Immediate cause of death	DURATION
Carcinoma of liver	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Julius Clapker, M.D. M. D. or other

Address: 88 W. Main Westminster Date signed: 6/18/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

6037

Reg. Dist. No. 70

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John O'Neal Crapster

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Helen Reindollar Crapster

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1889

8. AGE:	Years	Months	Days	If less than one day
	58	10	10	hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Postmaster--Taneytown Office

11. Industry or business

FATHER 12. Name John J. Crapster

13. Birthplace Md

MOTHER 14. Maiden name Mary Ellen O'Neal

15. Birthplace Pa

16. Informant Mrs. Helen Reindollar Crapster

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10, 1948 (month) (day) (year)

Cemetery or crematory Piney Creek Presbyterian

Location Taneytown--Rural

18. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

19. June 9, 1948 Athel M Mehring (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION E.S.T.

20. DATE OF DEATH June 7 1948 at 11:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death

	DURATION
Acute Coronary Occlusion	Few Min.
Due to (Cause undetermined)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Not Done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. S. McVaugh M.D. acting Deputy Medical Examiner

Address Taneytown, Md. Date signed June 9, 1948

6038

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

192

CERTIFICATE OF DEATH

Reg. Dist. No. 76

M

1. PLACE OF DEATH:
County: Carroll
City or town: Rural - Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs -
Hospital, institution, or street address where death occurred:
Union Mills
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Union Mills
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Wayne Lee Derring

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 14, 1939

8. AGE: Years: 9 | Months: 2 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Clarksburg W. Va.
(Town, county, and state)

10. Usual occupation: Delivery boy.

11. Industry or business: —

FATHER
12. Name: Leland Derring
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Pauline E. Nay
15. Birthplace: W. Va.

16. Informant: Leland Derring
Address: Westminster, Route 2 Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 6-22-48 (month) (day) (year)

Cemetery or crematory: Mount Vernon Cemetery
Location: Barbour County, West Virginia

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 6/20 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1948 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19.., to — 19..
and that I last saw h... alive on — 19..

Immediate cause of death: Struck by lightning — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 6-19-48
Where did injury occur? Rural - Westminster (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Home - Farm -
Means of injury: Struck by lightning Injured at work? —

23. SIGNATURE: James T. Roark Deputy Med. Examiner (M. D. or other)
Address: Westminster Md. Date signed: 6/19/48

I

T

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

6039

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 2 months 10 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1121 Ettimg Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Harmon Felton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 17, 1920

8. AGE: Years	Months	Days	If less than one day
27	6	11	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Harmon Felton
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Lillie Burke
15. Birthplace: Baltimore, Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/2/48 (month) (day) (year)

Cemetery or crematory: Arbutus Memorial Park

Location:

18. Funeral director: Mrs. George H. Hallenbeck

Address: 1631 David Hill Ave

19. June 28 1948 (Date rec'd by registrar) Albert R. Swarthout Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28 1948, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1947, to June 28 1948 and that I last saw h... im alive on June 28 1948

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Apr. 12 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben H. Braun, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 6/28/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6040

83a Bc

Reg. Dist. No. 74

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

I. PLACE OF DEATH:

County: Carroll

City or town: RuralSykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo, 11 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 mo, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 200 E. Barney Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: FISCHBECK, Agnes Sarah

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fem.	white	married

6.(b) Name of husband or wife: John A. Fischbeck

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): 8/11/84

8. AGE: Years	Months	Days	If less than one day
63	10	10	....hrs. ....min.

9. Birthplace: Baltimore City
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: ———

FATHER
12. Name: William Kirby
13. Birthplace: Maryland

MOTHER
14. Maiden name: Laura McGahah
15. Birthplace: ?

16. Informant: Files of Springfield State Hospital
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-25-48 (month) (day) (year)
Cemetery or crematory: Mount Olivet
Location: Frederick Avenue

18. Funeral director: James L. McCauley
Address: 130 East Fort Avenue

19. June 22 1948 (Date rec'd by registrar) Agnes Steen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21, 1948, at 5.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1948 to June 21 1948 and that I last saw her alive on June 21 1948

Immediate cause of death	DURATION
Terminal broncho-pneumonia	2 days
Due to: Cerebral hemorrhage	4 days
Due to: Arteriosclerosis with hypertension	about 1 yr
Other conditions: Psychosis with cerebral arteriosclerosis	" "

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ———

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work? ———

23. SIGNATURE: Martin Gross, M.D.
Martin Gross, M.D.
M. D. or other

Address: Sykesville, Md. Date signed: 6/21/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

6041

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Sykesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred: Springfield State Hosp. Sykesville Md
How long in hospital or institution? 14 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 739 W. Saratoga Street Balt.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Earl William Fritz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Separated

6.(b) Name of husband or wife BERTHA
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899 - January 21st

8. AGE: Years 50 | Months 4 | Days 28 | If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation clerk

11. Industry or business

FATHER 12. Name Jacob Fritz
13. Birthplace Germany

MOTHER 14. Maiden name Caroline Abel
15. Birthplace Germany

16. Informant MISS Matilda Fritz
Address 739 W. Saratoga Pl. Baltimore

17. BURIAL Date thereof JUNE 22 '48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory WESTERN
Location EDMONDSON AVE & LONGWOOD

18. Funeral director Harry H Wiehe
Address 4101 Edmondson Ave

19. June 21 19 48 A. W. Hedges
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19th 19 48 at 9:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19th 1948 19 to June 19th 19 48
and that I last saw h... alive on June 19th 19 48

Immediate cause of death — DURATION

active lung tuberculosis — 1 year

Due to

Due to

Other conditions Schizophrenia
(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jose Marquez M.D
M. D. or other
Address Springfield State Hosp. Date signed June 19th 48

6042

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. 20 Fenway Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary Lillian Gallamore

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 27, 1927

8. AGE: Years	Months	Days	If less than one day
20	8	2	hrs. min.

9. Birthplace: Twiggs County, Georgia
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Reese Gallamore
13. Birthplace: Georgia

MOTHER
14. Maiden name: Mary Moore
15. Birthplace: Georgia

16. Informant: Deceased
Address:

17. Burial, cremation, or removal. Which? Burial
Date thereof: July 2 - 1948 (month) (day) (year)
Cemetery or crematory: Union M. E.
Location: Aberdeen Md.

18. Funeral director: Henry Fanning & Sons
Address: Aberdeen Md.

19. June 29 1948 (Date rec'd by registrar)
Albert R Swarthout Local Deputy Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: June 29 1948 at 9:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1948, to June 29 1948 and that I last saw her alive on June 29 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 6/29/48

6043

Bc 61

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Rural - Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 27 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 1 mo., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Baltimore City
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1400 W. Lexington (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Charles Edward Green

3. (b) Social Security Number

4. Sex: Male
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.) Dec. 14, 1869

8. AGE: Years 78 | Months 6 | Days 6 | If less than one day ...... hrs. ...... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Teacher
11. Industry or business
FATHER 12. Name: Joseph Wesley Green
13. Birthplace: Md.
MOTHER 14. Maiden name: Elizabeth Carroll
15. Birthplace: Md.
16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-23-48 (month) (day) (year)
Cemetery or crematory: Ivy Hill
Location: Laurel Md
18. Funeral director: ~~F. C. Hopkins~~ DeWitt Donaldson
Address: Laurel Md
19. June 20 1948 (Date rec'd by registrar) C. Harry Steer, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20, 1948, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24, 1948, to June 20, 1948, and that I last saw him alive on June 20, 1948

	DURATION
Immediate cause of death: Myocardial degeneration	?
Generalized arteriosclerosis	?
Due to: Diabetes mellitus	?
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis (Include pregnancy within 3 months of death)	2 yrs.

Major findings of operations ...... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ...... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ...... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. (M. D. or other)
Address: Springfield State Hospital Date signed 6/20/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

St. Fourth 6044 61

Reg. Diat. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 yrs

Hospital, Institution, or street address where death occurred:

8 E. Green st.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 E. Green

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME William Taylor Grimm

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Emma Grimm

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 23 - 1878

8. AGE: Years	Months	Days	If less than one day
69	9	—	..... hrs. ..... min.

9. Birthplace Frud. Co. Md.

(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

FATHER

12. Name Taylor Grimm

13. Birthplace Frud. Co. Md.

MOTHER

14. Maiden name Mary Miller

15. Birthplace Frud. Co. Md.

16. Informant Elsie Mason Grimm

Address 8 E. Green, Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26-1948 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Uniontown, Md.

18. Funeral director W Bankard Son

Address Westminster, Md.

JUN 26 1948 19..... (Date rec'd by Registrar) Ray Fogle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23rd 1948 at 8.55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1- 1948 to June 23 1948 and that I last saw him alive on June 22 1948

Immediate cause of death	DURATION
Acute Cardiac Dilatation	10 hrs
Due to Diabetes Mellitus	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas R Tout M.D. M. D. or other

Address Westminster Md Date signed 6-25-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

6045

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 737 Forrest Street (If rurel, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Arthur ISAIAH GUNTER

3.(b) Social Security Number: 237-12-6664

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Dorothea Guther Gunter
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): February 27, 1910

8. AGE: Years	Months	Days	If less than one day
38	3	8	hrs. min.

9. Birthplace: Elm City, N. C. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/8/48 (month) (day) (year)
Cemetery or crematory: Mt. Calvery
Location: Brooklyn Md.
18. Funeral director: Elroy C. Watson
Address: 1000 Brantly ave

19. 6/4 (Date rec'd by registrar) 19 48 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4, 19 48 at 10.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24, 19 48 to June 4, 19 48 and that I last saw him alive on June 4, 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1947.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Wolfman M.D. M. D. or other
Address: Henryton, Md Date signed 6/4/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c

6046

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sunwood (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sunwood (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mildred LaRue Haines

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband ~~or wife~~: John S. Haines

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 15 - 1912

8. AGE: Years: 35 | Months: 10 | Days: 26 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll County, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER — 12. Name: James W. Randall

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Beaver

MOTHER — 15. Birthplace: Maryland

16. Informant: John S. Haines

Address: Sunwood, Md. R. D.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 6/14/48 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Uniontown Road

18. Funeral director: H. H. Hartsler & Sons

Address: Union Bridge & New Windsor, Md.

19. June 12 1948 (Date rec'd by registrar) Margaret R. England Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1948, at 12 (7) noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1948 to June 11 1948 and that I last saw h~~er~~ alive on June 4 1948

Immediate cause of death: Gunshot wound of chest — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 6-11-48

Where did injury occur? New Windsor (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (where?): Next neighbor

Means of injury: Shot gun Injured at work? no

23. SIGNATURE: James T. Wood Deputy Medical Examiner M. D. or other

Address: Westminster, Md. Date signed 6/11/48

6047

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months 27 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or Institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4 Vansant Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Vincent Roosevelt Henson

3.(b) Social Security Number: 214-05-1810

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Gladys Henson
6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): October 31, 1899

8. AGE: Years	Months	Days	If less than one day
48	7	23	hrs. min.

9. Birthplace: St. Margaret, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Jim Henson
13. Birthplace: Eastern Shore, Maryland

MOTHER
14. Maiden name: Mary Jane Horney
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-27-48 (month) (day) (year)
Cemetery or crematory: Broadneck Cem
Location: Shidaker, Md
18. Funeral director: William Rieman
Address: 108 Washington St. Annapolis, Md.

19. June 23 1948 (Date rec'd by registrar) Allen R. Smallhouse Local Deputy Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: June 23 1948 at 6:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27 1947, to June 23 1948 and that I last saw h... im alive on June 23 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Rieman, M. D.
M. D. or other
Address: Henryton, Maryland Date signed: 6/23/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

6048

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 month 27 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Ranch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 310 W. Hoffman Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Cornelius Hill

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Doris Hill

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): April 17, 1927

8. AGE: Years	Months	Days	If less than one day
21	2	2	....hrs. ....min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Matthew Hill
13. Birthplace: Virginia

MOTHER
14. Maiden name: Lorraine Ford
15. Birthplace: Virginia

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal? Which?) Buried Date thereof June 22/48
(month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: Adolphus Halstead

18. Funeral director: 917 Bond Hill Ave

Address:

19. June 19 1948 Albert R. Swankhaus
(Date rec'd by registrar) Local Deputy Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH June 19 19 48 at 1.50 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 23 19 48 to June 19 19 48 and that I last saw him alive on June 19 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 6/19/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JUN 21 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6049

930

Reg. Dist. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Ridgeville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Ridgeville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural--- Mt. Airy
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ALCINDA N. KAIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Joseph H. Kain
deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 6, 1863

8. AGE:

Years	Months	Days	If less than one day
84	7	15	hrs. min.

9. Birthplace: Montgomery Co. Maryland
(Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Robert A. Nelson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ann Shipley
15. Birthplace: Maryland

16. Informant: Mr. J. Howard Kain
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 6-24-48 (mooth) (day) (yenr)
Cemetery ~~or crematory~~: Pine Grove
Location: Mt. Airy, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. June 24 19 48 Thos D Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 19 48, at 1045 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18, 19 48 to June 21 19 48
and that I last saw her alive on June 19, 19 48

Immediate cause of death: Arteriosclerotic gangrene of left leg. — DURATION: 6 weeks

Due to: Arteriosclerotic cardiovascular disease. — 15 years

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James P. Kerr M.D.
M. D. or other
Address: Uniontown, Md. Date signed: 6/21/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 26 1948
BUREAU V. S.

6050

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

CERTIFICATE OF DEATH

Reg. Dist. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

County Home

How long in hospital or institution? 2 yrs 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Westminster Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Theodore King

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife Emma Powell King

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1866

8. AGE:

Years	Months	Days	If less than one day
82	3	26	hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Retired Dealer in live stock

11. Industry or business

FATHER 12. Name Julius King

13. Birthplace Germany

MOTHER 14. Maiden name Mata Unknown

15. Birthplace Germany

16. Informant Roy King

Address Littlestown, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 29, 1948. (month) (day) (year)

Cemetery or crematory St. Mary's

Location Silver Run, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. JUN 28 1948 19 (Date rec'd by registrar) Clay Fogle Dep Lee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27 1948, at 6.30A M

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from 4-1- 1948, to 6-27 1948

and that I last saw h[illegible] alive on 6-26- 1948

	DURATION
Immediate cause of death Uremia	Brief
Due to Enlarged Prostate	7 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations N/A

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address [illegible] Date signed 6-27-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6051

936

CERTIFICATE OF DEATH

Reg. Diat. No. 72

1. PLACE OF DEATH:
County Carroll
City or town Union Mills (Westminster R.D.1)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Union Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No. Westminster R.D.1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma Jane Leese

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Edward Leese
6.(c) If alive, give age 90 years

7. Birth date of deceased (mo., day, yr.) March 20 1868

8. AGE:

Years	Months	Days	If less than one day
80	2	12	hrs. min.

9. Birthplace Carroll County, Md.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business Housewife

FATHER
12. Name George Lippy
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Ellen Myers
15. Birthplace Carroll Co. Md.

16. Informant Lester H. Brock
Address Littlestown, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5 1948 (month) (day) (year)
Cemetery or crematory St. Marys Union Cemetery
Location Silver Run, Md.

18. Funeral director T. H. Fuss & Son
Address Littlestown, Pa. By R. A. Fuss

19 June 3rd 1948 (Date rec'd by registrar) Calvin Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1948, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to Arteriosclerotic C-V disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Shand Deputy Medical Examiner
M. D. or other
Address Westminster Md. Date signed 6/6/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6052

164c

Reg. Diat. No. 78

1. PLACE OF DEATH:

County: Carroll

City or town: Rural --- Woodbine

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural--Woodbine

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Fermont Linton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Corilla C. Linton

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): June 15, 1885

8. AGE:

Years	Months	Days	If less than one day
63	0	5	....hrs. ....min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Alfred Linton

13. Birthplace: Maryland

MOTHER

14. Maiden name: Dora Frost

15. Birthplace: Maryland

16. Informant: Mrs. Corilla C. Linton

Address: Woodbine, Md.

17. (Burial, ~~cremation, or removal. Which?~~) Burial Date thereof 6-23-48 (month) (day) (year)

Cemetery ~~or crematory~~: Freedom

Location: Freedom, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. (Date rec'd by registrar) 6-23-48 E. Mac Farris Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 1948 at 7:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..., 19..., to ..., 19...

and that I last saw h... alive on ..., 19...

Immediate cause of death	DURATION
Gunshot wound of Head	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Suicide Date of 6-20-48

Where did injury occur? Woodbine (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Home.

Means of injury 22 rifle Injured at work? No.

23. SIGNATURE James F. Marsh Deputy Medical Examiner M. D. or other

Address Westminster Md Date signed 6-20-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50 nc

6053

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 18 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 month, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1400 W. Lexington St.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME Jesse Franklin Long

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Perretta Mai Richards

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 9, 1872

8. AGE: Years	Months	Days	If less than one day
75	8	2	..... hrs. ..... min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: ?

11. Industry or business

FATHER — 12. Name: Jesse Franklin Long
13. Birthplace: Md.

MOTHER — 14. Maiden name: Georgianna Green
15. Birthplace: Md.

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 14, 1948 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. June 12, 1948 (Date rec'd by registrar) Harry Keer, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11, 1948 at 7:22 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24, 1948 to June 11, 1948 and that I last saw him alive on June 11, 1948.

Immediate cause of death	DURATION
Generalized arteriosclerosis	?
Chronic myocarditis	?
Due to: Carcinoma of left breast	?
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	10 mos.

(Include pregnancy within 3 months of death)

Major findings at operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town), (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall M.D. M. D. or other

Address: Springfield State Hospital Date signed: 6/14/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6054

830

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural, Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs, 4 mo, 7 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 3 yrs, 4 mo, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5831 Fairmount Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LUEHRS, William J.

3.(b) Social Security Number: 578-07-2505

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Emily H. Luehrs

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Nov. 24, 1889

8. AGE: Years	Months	Days	If less than one day
58	6	27	..... hrs. ..... min.

9. Birthplace: New York State (Manhattan or Bronx?)
(Town, county, and state)

10. Usual occupation: Electrical Engineer

11. Industry or business: ----

FATHER
12. Name: John Luehrs
13. Birthplace: Germany

MOTHER
14. Maiden name: ?
15. Birthplace: Germany

16. Informant: Files of Springfield State Hospital
Address: Sykesville, Md

17. Removal (Burial, cremation, or removal, Which?) Date thereof June 21 1948 (month) (day) (year)

Cemetery or crematory: Silver Spring, Md.

Location: .....

18. Funeral director: Wagner E. Humphrey, Inc.
Address: 8434 Georgia Ave. Silver Spring, Md

19. June 21 1948 (Date rec'd by registrar) Harley Beer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21, 1948 at prior to 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Cerebral hemorrhage	
Due to: Arteriosclerosis with hypertension	more than 5 yrs
Due to:	
Other conditions: Manic depressive psychosis	"

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James T. Marsh, Deputy Medical Examiner
M. D. or other

Address: Westminster Md Date signed 6-21-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6055

13C

Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? - 25 yrs

Hospital, Institution, or street address where death occurred:

Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Main St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Daniel Thomas Mays

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Carrie Rozella Mays

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): July 5 1883

8. AGE:

Years	Months	Days	If less than one day
64	11	19	....hrs. ....min.

9. Birthplace: Millers - Carroll Co. Md.

(Town, county, and state)

10. Usual occupation: - Farmer

11. Industry or business

FATHER

12. Name: Abraham Mays

13. Birthplace: Millers, Md

MOTHER

14. Maiden name: Martha Mays

15. Birthplace: Miller, Md.

16. Informant: Mrs Carrie Mays

Address: Manchester, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27/48 (month) (day) (year)

Cemetery or crematory: Manchester

Location: Carroll Co Md

18. Funeral director: Edward A Tipton

Address: Hampstead Md

19. June 25th 1948 (Date rec'd by registrar) W.P.A. P.S. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1948, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 12 1948 to Jun. 4 1948 and that I last saw him alive on Jun 21 1948

Immediate cause of death	DURATION
Far Advanced	
Due to: Tuberculosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. H. Hoard M. D. or other

Address: Manchester, Md Date signed June 24 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

6056

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months 12 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 718 W. Fairmount Ave.
(If rural, give LOCATION)

4.(a) If veteran, name war:

3.(a) FULL NAME: Eula Mae Mc Clinton

3.(b) Social Security Number: 213-26-6004

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 14, 1917

8. AGE: Years	Months	Days	If less than one day
30	11	20	hrs. min.

9. Birthplace: York S. Caroline
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: James Mc Clinton
13. Birthplace: Atlanta, Georgia

MOTHER
14. Maiden name: Mattie Robinson
15. Birthplace: York S. Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/5/48 (month) (day) (year)

Cemetery or crematory:

Location: High Point, N.C.

18. Funeral director: Mrs. Lee A. Stalla

Address: 163 Druid Hill Ave

19. June 3 1948 (Date rec'd by registrar) Albert R. Sauerbrey Registrar
Local Deputy

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: June 3 1948, at 3:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 22 1947 to June 3 1948 and that I last saw her alive on June 3 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Eileen Hoffman, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 6/3/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

6057

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 22 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton (a) If veteran, name war: ✓

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1622 E. Chase Street (If rural, give LOCATION)

3. (a) FULL NAME: Thomas Glover Moss

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	col	Married

6. (b) Name of husband or wife: Gertrude Moss

6. (c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): February 11, 1911

8. AGE: Years	Months	Days	If less than one day
37	3	27	..... hrs. ..... min.

9. Birthplace: Montgomery County, Alabama (Town, county, and state)

10. Usual occupation: Baseball

11. Industry or business:

FATHER — 12. Name: Willie Glover

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Luvelia Moss

15. Birthplace: Montgomery, Alabama

16. Informant: Deceased

Address:

17. (Burial, cremation, or removal. Which?) Date thereof: Shipped 6/8 (month) (day) (year)

Cemetery or crematory: Montgomery, Alabama

Location:

18. Funeral director: Mrs Robert Elliott daughter

Address: 1129 N. Caroline St

19. June 7 19 48 (Date rec'd by registrar) Albert R. Smallhamer Local Deputy Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: June 7 19 48 at 8:30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 13 19 48, to June 7 19 48 and that I last saw h... im alive on June 7 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan 1 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Maryland Date signed: 6/7/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6058

83a

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs 11 mos 3 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 23 yrs 11 mos 3 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Garrett Co.

City or town: Swanton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bessie Murphy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 56 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Garrett Co. (Town, county, and state)

10. Usual occupation

11. Industry or business Dependent

FATHER 12. Name Unk.

FATHER 13. Birthplace Unk.

MOTHER 14. Maiden name Unk.

MOTHER 15. Birthplace Unk.

16. Informant: Springfield Hosp. Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3, 1948 (month) (day) (year)

Cemetery or crematory: Springfield Hospital Cem.

Location: Sykesville Md.

18. Funeral director: Harry Keen

Address: Sykesville Md.

19. July 2 1948 (Date rec'd by registrar) Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30th 1948 at 9-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1924 to June 30 1948 and that I last saw h[illegible] alive on June 30th 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 wks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M.D. or other

Address: Sykesville Md. Date signed 7/3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

6059

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: near Taylorsville, R Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 62 Madison St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LILLY MAY NYGREN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Dohnea C. Nygren

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): July 31, 1881

8. AGE: Years: 66 | Months: 10 | Days: 17 | If less than one day: ... hrs. ... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: William Lindsay

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Martha Ogg

15. Birthplace: Maryland

16. Informant: Mrs. Philip Cummings

Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 6-21-48 (month) (day) (year)

Cemetery ~~or crematory~~: Westminster

Location: Westminster, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. 6-21-48 (Date rec'd by registrar) 19 ... E. M. Farver Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18, 1948, at 11:P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 17 1948, to June 18 1948

and that I last saw her alive on June 18 1948

Immediate cause of death	DURATION
Myocardial Insufficiency	2 hrs
Due to: Chr. Myocarditis	?
Due to: Obesity	?
Other conditions: Hypertension	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statisticaDy.

22. VIOLENCE: If death was due to external causes, fill in the followiog:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other

Address: Mt Airy, Md Date signed 6/20/48

6660

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Taneytown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clarence W. Ohler

3.(b) Social Security Number 219-14-7607

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Helen Eckard Ohler

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 13, 1898

8. AGE: Years	Months	Days	If less than one day
50	3	15	hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Operated a Garage

11. Industry or business

FATHER 12. Name Milton Ohler

13. Birthplace Md

MOTHER 14. Maiden name Sarah Coletts

15. Birthplace Md

16. Informant Helen Eckard Ohler

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 1, 1948 (month) (day) (year)

Cemetery or crematory Lutheran

Location Taneytown, Md

16. Funeral director C. O. Fuss & Son

Address Taneytown, Md

19. June 30, 1948 (Date rec'd by registrar) Ethel M. Melhorn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1948, at 10 20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Coronary Artery Disease	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Sharrer Deputy Medical Examiner M. D. or other

Address Westminster Md Date signed 6/29/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

6061

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 11 mo 23 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 yr 11 mo 23 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5904 Harford Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Mary Borosh Pandak

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Emery Pandar

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 17 - 1891

8. AGE:

Years	Months	Days	If less than one day
57	2	22	hrs. min.

9. Birthplace: Hungary
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER
12. Name: John Borosh
13. Birthplace: Hungary

MOTHER
14. Maiden name: Theresa Blagdan
15. Birthplace: Hungary

16. Informant: Mr. Emery Pandak

Address: 5904 Harford Rd. Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 9 1948 (month) (day) (year)

Cemetery or crematory: Springfield Hospital Cem.

Location: Sykesville Md.

16. Funeral director: Harry Heer

Address: Sykesville, Md.

19. June 8 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1st 1948, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1946, to June 1st 1948 and that I last saw her alive on June 1st, 1948

	DURATION
Immediate cause of death	
Lobar Pneumonia	2 wks
Due to	
Due to Arteriosclerosis	22 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Hastings M.D. M. D. or other

Address: Sykesville Md. Date signed: 6/1/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age if especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

6062

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

CERTIFICATE OF DEATH

Reg. Diat. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Rural
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Harvey L. Picking

3.(b) Social Security Number None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Edna B. Picking
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): April 20 - 1877
8. AGE: Years 71 | Months 1 | Days 15 | If less than one day ..... hrs. ..... min.
9. Birthplace: Carroll County Md.
(Town, county, and state)
10. Usual occupation: Operator of Farm
11. Industry or business: Retired
FATHER
12. Name: Tyler Picking
13. Birthplace: Penna.
MOTHER
14. Maiden name: Katie O. Bloom
15. Birthplace: Maryland
16. Informant: Mrs. Edna B. Picking
Address: New Windsor, Md. R.D.
17. Burial, cremation, or removal. Which?: Burial Date thereof: 6/7/48 (month) (day) (year)
Cemetery or crematory: Pipe Creek Cemetery
Location: Uniontown Road
18. Funeral director: H. W. Hartley & Sons
Address: Union Bridge & New Windsor, Md.
19. June 7 1948 (Date rec'd by registrar) Ester S. Bixler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 1948, at 7:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 1948 to June 4 1948
and that I last saw him alive on June 4 1948

	DURATION
Immediate cause of death: Coronary Thrombosis	8 Days
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Merritt E. Robertson M. D. or other
Address New Windsor, Md. Date signed June 5/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

6663

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city of town limits, write RURAL and give nearest town)
How long in above place of death? 7 months 12 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1520 Ashland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Henry Powell

3.(b) Social Security Number: 245-20-3543

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Separated

6.(b) Name of husband or wife: Mollie Powell
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): March 6, 1894

8. AGE: Years	Months	Days	If less than one day
54	3	2	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business

FATHER
12. Name: James Epps Powell
13. Birthplace: Virginia

MOTHER
14. Maiden name: Carrie Singleton
15. Birthplace: Virginia

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 10 1948 (month) (day) (year)
Cemetery or crematory City Morgue.
Location Baltimore

18. Funeral director: Mrs. Samuel T. Hensley
Address 578 W. Biddle St.

19. June 8 1948 (Date rec'd by registrar) Albert R. Sussenbrunn Registrar
Local Deputy.

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH June 8 1948 at 3:30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 27 1947, to June 8 1948
and that I last saw him alive on June 8 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	October 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Reuben W. Swan, M. D.
M. D. or other
Address Henryton, Maryland Date signed 6/8/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

6064

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 933 Hubbard Court
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lillian Lucinda Redding (Green)

3.(b) Social Security Number

4. Sex: female
5. Color or race: col
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): February 26, 1896
8. AGE: Years 52 Months 4 Days 4 If less than one day hrs. min.
9. Birthplace Alexander, Virginia
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
FATHER 12. Name Turner Murphy
13. Birthplace N. Carolina
MOTHER 14. Maiden name Rachel Unknown
15. Birthplace Unknown
16. Informant Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/3/48 (month) (day) (year)
Cemetery or crematory Mt. Calvary
Location [illegible]
18. Funeral director [illegible]
Address 1216 E. Caroline St - Balto. Md.
19. June 30 1948 (Date rec'd by registrar) Albert R. Smallwood Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1948 at 4:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1948 to June 30 1948 and that I last saw her alive on June 30 1948
Immediate cause of death: Pulmonary Tuberculosis — DURATION: Nov. 1947
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben H. Kwan, M.D. M. D. or other
Address Henryton, Maryland Date signed 6/30/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

6065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or Institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1129 Pennsylvania Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: 2

3.(a) FULL NAME: St. Louis Reveley

3.(b) Social Security Number: 230-03-0274

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Beatrice Reveley

6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): February 20, 1918

8. AGE: Years	Months	Days	If less than one day
30	4	6	..... hrs. ..... min.

9. Birthplace: Elmhurst, Virginia (Town, county, and state)

10. Usual occupation: Welder

11. Industry or business:

FATHER — 12. Name: William Reveley

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Ida Sparrow

15. Birthplace: Virginia

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/1/48 (month) (day) (year)

Cemetery or crematory: Betts Natural

Location: Balto City

18. Funeral director: Wm A Jackson

Address: 916 Penna Ave

19. June 26 1948 (Date rec'd by registrar) Albert R. Swanborn Local Deputy Registrar

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH: June 26 1948 at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1948 to June 26 1948 and that I last saw him alive on June 26 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 28 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Maryland Date signed 6/26/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Re 6066

55 e

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days 6 mo 14 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 days 6 mo 14 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Valentine Riley.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Matilda Pottswell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 14th 1892

8. AGE:

Years	Months	Days	If less than one day
55	6	22	hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Cooker

11. Industry or business: Cannery

FATHER — 12. Name: Charles Riley

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Bendina Schweiger

MOTHER — 15. Birthplace: Md

16. Informant: Rose Elizabeth Conroy

Address: 402 S. Washington Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8, 1948 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore Md.

18. Funeral director: LILLY and ZEILER, INC.

Address: 403 S. Wolfe St. Balto 31.

19. June 6 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5th 1948 at 2:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 22d 1937, to June 5th 1948 and that I last saw h[illegible] alive on June 3rd 1948

Immediate cause of death	DURATION
Due to: Carcinoma of the cervical region	1 3 months
Due to: ut. cervical	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Gaston M.D. M.D. or other

Address: Sykesville Md. Date signed 6/9/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6667

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months 23 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince George's

City or town High Ridge Park, Md. P.O. Laurel, (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME: Carrie Rebecca Rustin

3.(b) Social Security Number: 214-16-5546

4. Sex: female

5. Color or race: col

6.(a) Single, married, widowed, or divorced: Separated

6.(b) Name of husband or wife: Joseph James Rustin

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): August 22, 1919

8. AGE: Years: 28 Months: 10 Days: 7 If less than one day: hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: George Robinson

13. Birthplace: N. Carolina

MOTHER

14. Maiden name: Carrie Clark

15. Birthplace: Cecil County, Maryland

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 2 1948 (month) (day) (year)

Cemetery or crematory Mt Calvary Cemt

Location A.A. Co Md

18. Funeral director Isaiah F Brown Co

Address 105 W Montgomery St

19. June 29 1948 (Date rec'd by registrar) Albert R. Sundheim Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1948 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6 1947 to June 29 1948 and that I last saw her alive on June 29 1948

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	April 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other

Address Henryton, Maryland Date signed 6/29/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

6668

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Annie M. Sensenney

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: Ernest Sensenney

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 12 - 1870

8. AGE: Years: 77 Months: 11 Days: 10 If less than one day: ____ hrs. ____ min.

9. Birthplace: Carroll County Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At home

FATHER

12. Name: Manassah Repp

13. Birthplace: Maryland

MOTHER

14. Maiden name: Elizabeth Pantz

15. Birthplace: Maryland

16. Informant: Elizabeth Repp

Address: Union Bridge R.D. Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 6/25/48 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cem

Location: Uniontown Road

18. Funeral director: W. H. Hartzler & Sons

Address: Union Bridge & Westminster Md

19. (Date rec'd by registrar) 19 48 Lewis L. Repp Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 1948 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 48 to June 22 19 48 and that I last saw h alive on June 22 19 48

Immediate cause of death: Coronary artery disease — DURATION: months

Due to: Diabetes — DURATION: years

Due to: ____

Other conditions: ____

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work? ____

23. SIGNATURE: James T. Maund M D

Address: Westminster Md M. D. or other

Date signed: 6/23/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

6069

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 761 W. Mulberry Street (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JAMES SEWELL

3.(b) Social Security Number: 218-01-4342

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Josephine Sewell
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 4, 1913

8. AGE:

Years	Months	Days	If less than one day
35	4	14	hrs. min.

9. Birthplace: Stevensville, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: James Daniel Sewell
13. Birthplace: Easton, Md.
MOTHER 14. Maiden name: Janie Johnson
15. Birthplace: Easton, Md.
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/22/48 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cem
Location:
18. Funeral director: Mrs. George F. Holland
Address: 1631 Druid Hill Ave
19. 6/18 19 48 (Date rec'd by registrar) Albert L. Trautham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18, 1948 at 2.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21, 1948 to June 18, 1948 and that I last saw h im alive on June 18, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 6/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6070

1312

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Annie Elizabeth Sherfey

3.(b) Social Security Number 213-16-1507

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife John W. J. Sherfey 6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) April 24 - 1892

8. AGE: Years	Months	Days	If less than one day
56	1	29	hrs. min.

9. Birthplace Fred. Co. Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George W. Mumford

13. Birthplace Montgomery Co. Md.

MOTHER 14. Maiden name Annie R. Eigler

15. Birthplace Fred. Co. Md.

16. Informant Mrs Annie Gorsuch

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27-1948 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

JUN 26 1948 19 (Date rec'd by Registrar) Ray Fogle Dep Reg Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1948 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1941 to June 22 1948 and that I last saw her alive on June 21 1948

Immediate cause of death	DURATION
Coronary disease	5 + months
Due to Cardio-vascular renal disease	3 + yrs
Due to	
Other conditions Edema, marked	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE C. Reese Wilkens M. D. or other

Address Westminster Date signed June 24 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6071

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Sykesville, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Liberty Rd. (Oakland)
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Walter Herbert Shipley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice M. Webster

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Mar. 30th 1888

8. AGE:

Years	Months	Days	If less than one day
60	2	23	____ hrs. ____ min.

9. Birthplace: Hillsdale Balto Co.
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: Woolen Mill

FATHER
12. Name: William Shipley
13. Birthplace: Balto. Co.

MOTHER
14. Maiden name: Elmira Hodges
15. Birthplace: Balto. City

16. Informant: Mrs. Alice Shipley
Address: Sykesville

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 25, 1948 (month) (day) (year)

Cemetery or crematory: Cemetery, Oakland

Location: Oakland, Sykesville Md.

18. Funeral director: D. Harry Weer

Address: Sykesville Md.

19. June 22 1948 D. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22, 1948 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22, 1948 to June 22, 1948 and that I last saw h alive on June 22, 1948

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of Injury ____ Injured at work?

23. SIGNATURE: Wm. E. Martin M. D.
M. D. or other

Address: Randallstown Date signed 6/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6072

83a

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2 West George St.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Alice L. Smith

3.(b) Social Security Number: 213-05-1355

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Guy B. Smith

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): August 29, 1893

8. AGE: Years	Months	Days	If less than one day
54	9	23	...hrs. ...min.

9. Birthplace: Westminster, Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER

12. Name: John H. Wilhide

13. Birthplace: Maryland

MOTHER

14. Maiden name: Lydia Miller

15. Birthplace: Maryland

16. Informant: Guy B. Smith

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 6/23/48 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 6/22 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1948, at 3½a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1948, to June 21 1948

and that I last saw h... alive on June 20 1948

	DURATION
Immediate cause of death: Cerebral Hemorrhage	5 da
Due to: Arteriosclerosis (General) + Hypertension	Several yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed 6/24/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6073

1148

Reg. Diat. No. 81

1. PLACE OF DEATH

County: Carroll Co

City or town: Union Bridge Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33yr

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME Joseph Covington Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Black	W

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 74 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Pleasanton (Town, county, and state)

10. Usual occupation Carl Co

11. Industry or business

FATHER
12. Name Andrew Smith
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Mrs Martha Matthews
Address Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-11-48 (month) (day) (year)

Cemetery or crematory Mt Joy

Location Mt Union Town Md

18. Funeral director Raymond K Wright

Address Union Bridge Md

19. June 10, 1948 Leila Mohr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1948, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 1948, to June 8 1948 and that I last saw h.. alive on June 7 1948

Immediate cause of death	DURATION
Pulmonary Abscess	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J H Legg M. D. or other

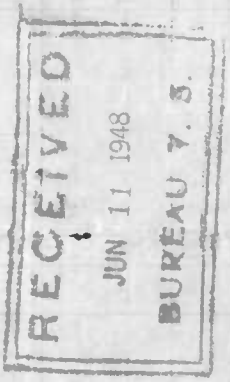
Address Union Bridge Date signed 6-9-48

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

David Smith Wilmington N.J.



1948
74
1874

6074

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Sykesville Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Ellen Snowden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	Married

6.(b) Name of husband or wife: Preston H. Snowden

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 1, 1861

8. AGE: Years	Months	Days	If less than one day
87	5	19	hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Henry Pavis

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: unk. Walker

MOTHER — 15. Birthplace: Md.

16. Informant: Preston H. Snowden

Address: Sykesville Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22, 1948 (month) (day) (year)

Cemetery or crematory: West Liberty Cem.

Location: Howard Co., Md.

18. Funeral director: Harry Kees

Address: Sykesville Md.

19. June 19 1948 (Date rec'd by registrar) Harry Kees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 1948 at 2 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1st 1948 to June 18, 1948 and that I last saw h alive on June 16, 1948

Immediate cause of death	DURATION
Carcinoma of uterus	3 y
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm E. Martin M. D. or other

Address: Randallstown Md Date signed 6/19/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6075

160

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Hoods Mill Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Dorsey Franc Stanbitz

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Geneva Stanbitz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 11, 1906

8. AGE: Years	Months	Days	If less than one day
42	-	10	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER

12. Name: Franc Stanbitz

13. Birthplace: Md.

MOTHER

14. Maiden name: Mary A. Rupprecht

15. Birthplace: Md.

16. Informant: Mrs. Geneva Stanbitz

Address: Woodbine Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23, 1948 (month) (day) (year)

Cemetery or crematory: Freedom Cem.

Location: Carroll Co. Md.

18. Funeral director: C. Harry Weer

Address: Sykesville Md.

19. 6/21/48 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1948, at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19.. to — 19..

and that I last saw h... alive on — 19..

Immediate cause of death	DURATION
Coronary artery disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: James T. Marsh, Deputy, Medical Examiner M. D. or other

Address: Westminster Md. Date signed 6/21/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

6076

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

938

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

County: Carroll

City or town: Keymar Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Keymar Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Margaret B Starr

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: John N Starr

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 19 - 1869

8. AGE:

Years	Months	Days	If less than one day
78	9	7.	..... hrs. ..... min.

9. Birthplace: Littlestown, Penna (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: Peter Baker

FATHER — 13. Birthplace: Penna

MOTHER — 14. Maiden name: Martha Baker

MOTHER — 15. Birthplace: Penna

16. Informant: John N Starr

Address: Keymar, Md RD

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28 - 1948 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Clear Ridge Maryland

18. Funeral director: D.D. Hartzler & Sons

Address: Union Bridge & New Windsor Md.

19. June 29 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1948, at 1:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 1948 to June 26 1948 and that I last saw h.. alive on June 26 1948

Immediate cause of death	DURATION
Chronic myocarditis	
Due to arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J H Legg M. D. or other

Address: Union Bridge Date signed: 6-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6077

164a

Reg. Dist. No. 77

1. PLACE OF DEATH:

County: Carroll

City or town: Hampstead - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hampstead - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Virginia Steger

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: George Steger

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Sept 25-1901

8. AGE:

Years	Months	Days	If less than one day
46	9	4	hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER

12. Name: William Coker

13. Birthplace: Md

MOTHER

14. Maiden name: Cora Ruby

15. Birthplace: Md

16. Informant: Mr Geo Steger

Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 1/48 (month) (day) (year)

Cemetery or crematory: Manchester Md

Location: Carroll Co

18. Funeral director: Edw C Tipton

Address: Hampstead Md

June 30 19 48 (Date rec'd by registrar) John S. Hughes Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 1948 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Suffocation.	
Due to: (b) Hanging.	
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: June 29-48

Where did injury occur? Hampstead (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Hanging by neck Injured at work? no.

23. SIGNATURE: James T. Ward Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed: 6/29/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6078

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: CARROLL

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs., 2 months, 26 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 6 yrs., 2 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Williams Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ANNIE STEGMAIER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 4, 1908

8. AGE: Years	Months	Days	If less than one day
39	10	18	hrs. min.

8. Birthplace: Cumberland, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: John Stegmaier
13. Birthplace: Cumberland, Maryland

MOTHER
14. Maiden name: Annie Detterman
15. Birthplace: Cumberland, Maryland

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 25, 1948 (month) (day) (year)
Cemetery or crematory: St. Peter's Cem.
Location: Cumberland Md.

18. Funeral director: John J. Hafer
Address: Cumberland Md.

19. June 22 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: June 22 19 48 at 6:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 19 48 to June 22 19 48 and that I last saw her alive on June 22 19 48

Immediate cause of death — DURATION

Pulmonary Tuberculosis — 2 mos

Due to:

Due to:

Other conditions: Psychosis with convulsive disorder, epil. deterioration — 29 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 6/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

6079

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 81

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 8 yrs

Hospital, institution, or street address where death occurred:

R.D. 1.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. 1.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Joseph Emory Stitely

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife Florence E. Lambert

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 11 - 1860

8. AGE: Years	Months	Days	If less than one day
88	4	13	..... hrs. ..... min.

9. Birthplace Frad. Co. Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name George Stitely

13. Birthplace Frad. Co. Md.

MOTHER

14. Maiden name Margaret Fillinger

15. Birthplace Frad. Co. Md.

16. Informant Mrs. Percy Wolfe

Address Union Bridge R.D. 1. Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 26-1948 (month) (day) (year)

Cemetery or crematory Pipe Creek Cem.

Location Uniontown, Md.

18. Funeral director H. Bankard & Son

Address Westminster. Md.

19. June 26 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24th 1948 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1948 to June 24th 1948 and that I last saw h.. alive on June 24th 1948

Immediate cause of death

	DURATION
Acute Cerebral Hemorrhage	3 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Lucien Bare (M.D.) M. D. or other

Address Westminster Md. Date signed 6/27/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as to age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6080

832

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll ~~56~~

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 144 E. Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Fannie Roselle Stocksdale

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Chas. Norris Stocksdale

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 16, 1868

8. AGE: Years	Months	Days	If less than one day
80	1	5	..... hrs. ..... min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Eli T. Buckingham

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Emma Nelson

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Fannie Buckingham

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 6/24/48 (month) (day) (year)

Cemetery or crematory: Finksburg Cemetery

Location: Finksburg, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 6/22 19 48 H. L. Woodward Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 19 48 at 9½ p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James T. Moore, Deputy Med. Examiner M. D. or other

Address ..... Md Date signed 6/24/48

M

I

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

6081

932

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 22 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 month, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6009 Burgess Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: OLIVIA DOROTHEA STONNELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: William B. Stonnell
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): April 13, 1899

8. AGE: Years	Months	Days	If less than one day
49	1	19	hrs. min.

9. Birthplace: Baltimore City
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: John Olaf Knudson
13. Birthplace: Norway
MOTHER 14. Maiden name: Elizabeth Warner
15. Birthplace: New York
16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4, 1948 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville Md.
18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St.
19. June 2 1948 (Date rec'd by registrar) Harry Kees Registrar

MEDICAL CERTIFICATION

DST

20. DATE OF DEATH: June 2, 1948 at 6:35 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1948 to June 2 1948 and that I last saw h...er alive on June 2 1948

Immediate cause of death	DURATION
Bronchopneumonia, Terminal	1 day
Due to Hypertensive Cardiovascular disease	2
Due to Generalized arteriosclerosis	2
Due to Cerebral thrombosis	2 days
Due to	
Other conditions Psychosis with cerebral arteriosclerosis	6 mos

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. (M. D. or other)
Address: Sykesville, Maryland Date signed: 6/2/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6682

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Billingslea 932

Reg. Dist. No. 76

M

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3-9 yrs
Hospital, institution, or street address where death occurred:
R.D. 2.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Agnes Strevig

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife George F. Strevig
6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Feb. 20 - 1889

8. AGE:

Years	Months	Days	If less than one day
3-9	4	4	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name William McGee
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Sarah Henry
15. Birthplace Carroll Co. Md.

16. Informant George F. Strevig
Address Westminster R.D. 2. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28-1948 (month) (day) (year)
Cemetery or crematory Rinker Cemetery
Location Westminster, Md.

18. Funeral director H. Bankard & Son
Address Westminster, Md.

19. JUN 26 '48 (Date rec'd by registrar) 19 Ray Fogle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24th 1948, at 10 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Feb. 1 1947 to June 24th 1948 and that I last saw her alive on June 24th 1948

	DURATION
Immediate cause of death Chronic Myocarditis	5 yrs.?
Due to —	
Due to —	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. J. Billingslea, M.D.
M. D. or other
Address Westminster Md. Date signed 6-25-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6083

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 689 W. Mulberry Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Rosa Lee Sydnor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Simgle

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 3, 1926

8. AGE:

Years	Months	Days	If less than one day
22	5	3	hrs. min.

9. Birthplace: Nomini Grove, Virginia
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Willie Burell
13. Birthplace: Virginia

MOTHER
14. Maiden name: Maude Sydnor
15. Birthplace: Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/15/48 (month) (day) (year)

Cemetery or crematory: mt calvary

Location:

18. Funeral director: A Halstead

Address: 918 Druid Hill ave

19. June 6 1948 (Date rec'd by registrar) Albert R. Smallhouse Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 19 48 at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 19 48 to June 6 19 48 and that I last saw her alive on June 6 19 48

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	June 7 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Nathan D. Foreman, M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 6/6/48

6084

9 4 a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County: CARROLL
City or town: SYKESVILLE (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)
Street No. 307 Windsor Street (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME FARWELL EDWARD THAYER
3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Annie L. Urguhart
6.(c) If alive, give age: Unk. years
7. Birth date of deceased (mo., day, yr.): 9/27/1875

8. AGE: Years	Months	Days	If less than one day
72	8	11	... hrs. ... min.

9. Birthplace: Cambridge, Massachusetts (Town, county, and state)
10. Usual occupation: Owner of house-painting business
11. Industry or business:
FATHER 12. Name: Farwell J. Thayer
13. Birthplace: Massachusetts
MOTHER 14. Maiden name: Bertha Hussey
15. Birthplace: Maine
16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: June 10, 1948 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: P. G. Co. Md.
18. Funeral director: C Harry Weer
Address: Sykesville, Md.
19. June 9 1948 (Date rec'd by registrar) C Harry Weer Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: June 8 1948 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29, 1948, to June 8 1948 and that I last saw her alive on June 8, 1948

Cause	DURATION
Immediate cause of death: Subdural hemorrhage Left side due to arteriosclerosis	1 month
Due to: old infarct of Left ventrical of Heart (over)	1 year
Due to: Ventrical (infarct)	
Other conditions: Senile Psychosis	?

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: M Virginia Beyer M.D. (M. D. or other)
Address: Sykesville - Md Date signed: June 8-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6085

932

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all his life

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or Institution? since Sept. 18, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Springfield State Hospital

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: THOMAS, Alpheus

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of ~~husband or~~ wife: Bessie Thomas

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): May 4, 1882

8. AGE: Years	Months	Days	If less than one day
66	1	19	....hrs. ....min.

9. Birthplace: Sykesville, Carroll Co. Md. (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: ---

FATHER

12. Name: Ruben Thomas

13. Birthplace: Sykesville, Md.

MOTHER

14. Maiden name: Laura - (unkown)

15. Birthplace: Sykesville, Md

16. Informant: Mrs. Bessie Thomas

Address: Sykesville, Maryland

17. Burial (Burial, ~~cremation, or removal~~ Which?) Date thereof 6-26-48 (month) (day) (year)

Cemetery ~~or crematory~~: White Rock

Location: Berrett, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. June 25 1948 (Date rec'd by registrar) C. Haney Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23 1948 at 5.55 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 18 1947 to June 23 1948 and that I last saw him alive on June 23 1948

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	more than 1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE: Martin Gross, M.D. Martin Gross, M.D.

Address: Sykesville, Md M. D. or other

Date signed 6/23/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

6086

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: County: Carroll; City or town: Sykesville, Md. (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? Life; Hospital, Institution, or street address where death occurred: ; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State: Maryland County: Carroll; City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town); Street No. (If rural, give LOCATION); 2.(a) If veteran, name war

3.(a) FULL NAME: Bertha Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	Widow

6.(b) Name of husband or wife: Clarence Thomas; 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 25 1887

8. AGE: Years	Months	Days	If less than one day
60	5	10	hrs. min.

9. Birthplace: Sykesville Carroll Co. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Henry Rhuston

13. Birthplace: Sykesville

MOTHER — 14. Maiden name: Alvina Squirrel

15. Birthplace: Sykesville

16. Informant: Alvina King; Address: Sykesville

17. Burial (Burial, cremation, or removal, which?) Date thereof June 7 1948 (month) (day) (year)

Cemetery or crematory: White Rock; Location: Carroll Co. Md.

18. Funeral director: Harry Heer; Address: Sykesville Md.

19. June 5 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 1948 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19 to death 19

and that I last saw h.e.r alive on 6/4/48 19

Immediate cause of death: hypertensive cardio-vascular disease with chronic nephritis

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: W. H. Lawson M.D. M. D. or other

Address: Sykesville Date signed 6/5/48

6087

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

Reg. Dist. No. 76

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1 - Mr Gamber.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Alma L. Wailes

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Joseph C. Wailes

6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): December 30, 1863

8. AGE: Years	Months	Days	If less than one day
84	5	19	..... hrs. ..... min.

9. Birthplace: Uniontown, Md. (Town, county, and state)

10. Usual occupation: Schoolteacher (retired)

11. Industry or business

FATHER 12. Name: David Segafoose

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Ellen Fleagle

MOTHER 15. Birthplace: Maryland

16. Informant: Joseph C. Wailes

Address: Sykesville, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 6/22/48 (month) (day) (year)

Cemetery or crematory: Lorraine Park Cemetery

Location: Baltimore, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 6/28 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 19 48 at 6½p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-27-'48 to 6-18 1948

and that I last saw h[illegible] alive on 6-18 1948

	DURATION
Immediate cause of death: Cardiac Decompensation	10 mo
Due to: Hypertensive C-V. Disease	6 yrs
Due to:	
Other conditions: Indirect Inguinal Hernia	6 yrs
Chr nephritis	6 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. D. Eagles, M.D. M. D. or other

Address: Reisterstown, Md. Date signed: 6-20-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6088

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months 29 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City (If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F. D. #2 (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lawrence Fenninger Waters

3.(b) Social Security Number: 218-20-7565

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 25, 1929

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
19	4	16		

9. Birthplace: Pocomoke City, Maryland (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business:

FATHER
12. Name: Edward Waters
13. Birthplace: Pocomoke City, Md.

MOTHER
14. Maiden name: Katie Wilson
15. Birthplace: Pocomoke City, Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-13-48 (month) (day) (year)
Cemetery or crematory: Glenwood
Location: Pocomoke City Md
18. Funeral director: Watson Funeral Home
Address: Pocomoke City Md

19. June 10 1948 (Date rec'd by registrar) Allen R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: June 10 19 48 at 6:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12 19 48 to June 10 19 48 and that I last saw him alive on June 10 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. (M. D. or other)
Address: Henryton, Maryland Date signed: 6/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6089

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 2-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 112 S. Hammerbacker Court
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Frances Watts

3.(b) Social Security Number: 220-22-3007

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 28, 1906

8. AGE: Years	Months	Days	If less than one day
41	11	27	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Horace Watson
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Rachel Brown
15. Birthplace: Baltimore, Maryland

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Burial Date thereof: 6 29 48 (month) (day) (year)
Cemetery or crematory: Mt Calvary Ct.
Location: Anne Arundle County
18. Funeral director: Walter B Spriggs
Address: 139 W Hamburg st.

19. (Date rec'd by registrar) June 24 19 48 Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 19 48, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 19 48 to June 24 19 48 and that I last saw h er alive on June 24 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben H Swan, M. D.
M. D. or other
Address: Henryton, Maryland Date signed: 6/24/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6690

932

Reg. Dist. No. 27

1. PLACE OF DEATH:
County Carroll
City or town Finksburg (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Finksburg - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary F. Wilhelm

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 24-1868

8. AGE: Years 80 | Months 3 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Benj Wilhelm
13. Birthplace Md

MOTHER 14. Maiden name Phoebe Ingham
15. Birthplace Md

16. Informant Mrs Georgette Hal
Address Finksburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 1948 (month) (day) (year)

Cemetery or crematory Forest
Location Balto Co.

18. Funeral director Edw C Gipton
Address Hampstead Md

19. July 1 19 48 (Date rec'd by registrar) L.R. Woodward John S. Hughes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29-48 19 ..... at 7:59 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to 6-29-48 19 .....
and that I last saw h 21 alive on 6-28-48 19 .....

Immediate cause of death	DURATION
Myocarditis	
Chronic emphysema	4 yrs
Due to Hypostasis	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE James G. Schell M. D. or other
Address Westminster Md Date signed 6/29/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6691

97

81

Reg. Dist. No.

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mollie Roberts Williams

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	widowed

6.(b) Name of husband or wife: John H. Williams

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1877

8. AGE: Years: 71 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Carroll County, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

MOTHER FATHER

12. Name: John Roberts

13. Birthplace: Maryland

MOTHER

14. Maiden name: Eliza Bowers

15. Birthplace: Maryland

16. Informant: Charles Roberts

Address: Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/28/48 (month) (day) (year)

Cemetery or crematory: Mt. Joy Cemetery

Location: Union Bridge, Md.

18. Funeral director: C. L. Fletcher & Sons

Address: Union Bridge & New Windsor, Md.

19. June 25 1948 (Date rec'd by registrar) Lester L. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 1948, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1948 to June 25 1948 and that I last saw h[illegible] alive on June 20 1948

Immediate cause of death: Arteriosclerosis — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Date signed: 6-25-48

6692

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 27 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1108 Whatcoat Street
(If rural, give LOCATION)

(a) If veteran, name war: 2

3. (a) FULL NAME: Sam Wilson

3. (b) Social Security Number: 240-10-4005

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 25, 1915

8. AGE:

Years	Months	Days	If less than one day
32	9	28	hrs. min.

9. Birthplace: Marriottsville, S. Caroline
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Joe Wilson
13. Birthplace: S. Carolina

MOTHER
14. Maiden name: Unknown
15. Birthplace: S. Carolina

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Shipped Date thereof 6/26/48 (month) (day) (year)

Cemetery or crematory: Maryville South Carolina

Location:

18. Funeral director: Walter B. Spriggs

Address: 1390 W Hamburg St

19. June 22 1948 (Date rec'd by registrar) Albert R. Swanborn Local Deputy Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: June 22 1948 at 6:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 26 1948 to June 22 1948 and that I last saw him alive on June 22 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec. 6 1947

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben M. Swan, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 6/22/48

6093

95c

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs. 8 mos.

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 16 yrs. 8 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Springfield State Hospital
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WRIGHT, ELLA MAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Emory R. Wright (deceased)

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 28, 1887

8. AGE: Years	Months	Days	If less than one day
61	2	22	..... hrs. ..... min.

9. Birthplace: Pratt, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Enos Bennett
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Mary Chaney
15. Birthplace: Allegany County, Md.

16. Informant: Hospital Records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22, 1948 (month) (day) (year)

Cemetery or crematory: Clanesville Cem.

Location: Allegany Co. Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. June 20 1948 (Date rec'd by registrar) Nancy Keer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1948, at 8:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 1948, to June 19, 1948 and that I last saw her alive on June 19 1948

Immediate cause of death	DURATION
Cardiac Decompensation and Shock	8 hrs
Due to: Acute Coronary Occlusion	8 hrs
Due to:	
Other conditions: Dementia Praecox	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Morton Jacobs M.D.

Address: Springfield State Hosp. M. D. or other

Date signed: June 19, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M